STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observations, review of facility policy and interviews for one of eight sampled residents (Resident #8) observed for dining, the facility failed to provide a dignified dining experience. The finding includes: Resident #8's diagnoses included muscle weakness (generalized), contracture of the left hand, and unspecified abnormal involuntary movements. The quarterly MDS assessment dated [DATE] identified Resident #8 had severely impaired cognition and was dependent for eating, oral hygiene, toileting, bathing and dressing. Resident #8's care plan dated 5/15/24 identified an ADL (activities of daily living) self-care performance deficit and noted the resident required extensive to total assist related to impaired balance, limited mobility, and limited range of motion. Care plan interventions directed: supervise and feed as tolerated, sit upright at a 90-degree angle with eating and drinking, encourage small bites, assist with all meals (total feed). Observation of the lunch meal on 6/4/24 at 12:57 PM identified two of the three residents at a dining table in the main dining area were served their meals. At 1:00 PM, Resident #8 was served his/her meal. The two other residents at the table were eating while Resident #8's meal remained in front of him/her with the cover in place over the plate. At 1:12 PM NA#1 came over to Resident #8 to assist with feeding the resident. NA#1 stood to the left side of Resident #8 and fed him/her lunch, the discrepancy. Interview with the Administrator on 6/4/24 at 1:25 PM identified that NA#1 should be seated while feeding Resident #8. The Administrator then approached NA#1 and instructed NA #1 to sit down. Once seated NA#1 was able to assist Resident #8 with the remainder of the meal. Interview with NA #1 on 6/4/24 at 1:32 PM identified she was aware that she should be seated while feeding residents; however, she found it more difficult due to her being short and the resident being tall. She further identified that Resident #8 is usually in bed for lunch. The facility did not have a policy regarding the practice of having the nurse aides sit down while providing assistance during dining. A training on customer service in the dining room was received and it identified that eye contact should be maintained during the dining experience.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of facility policy, and interviews for two sampled residents (Resident #17 and Resident #26) reviewed for positioning and range of motion (ROM), the facility failed to ensure that the use of an assistive device was included in the comprehensive care plan. The findings included: 1. Resident #17 was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus without complications, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, chronic pain syndrome, blindness of the right eye. The quarterly MDS assessment dated [DATE] identified Resident #17 had moderately impaired cognition, was dependent with toilet transfers and chair to bed or chair to chair transfers and required maximum assistance for upper and lower body dressing. The assessment further identified a functional limitation in range of motion to one side of both the upper and lower extremities. The care plan dated 3/13/2024 identified Resident #17 required assistive devices for mobility and identified the resident used a custom wheelchair. Additionally, the care plan identified the resident used a bed rail to assist themselves with ADLs. The physician's orders dated 5/10/2024 identified orders for a physical therapy evaluation and treatment 3 to 5 times weekly for therapeutic exercises, therapeutic activities, neurology re-education, and gait training, occupational therapy evaluation and treatment as indicated 3 to 5 times per week for 8 weeks to include bilateral upper extremities, and self-care training. Observation on 6/4/2024 at 1:11 PM identified Resident #17 in the dining room, seated in the wheelchair feeding himself/herself lunch. He/she had a sling on the left arm. Interview with the Therapy Director on 6/5/2024 at 9:56 AM identified Resident #17 was last evaluated on 5/26/24 when the resident returned from a hospitalization . PT and OT services continued once the resident was readmitted to the facility. The Therapy Director further identified that Resident #17 previously had an order for a sling but when he/she returned from the hospital the sling order was not reordered. She further noted that the occupational therapist must have missed it on her evaluation. Additionally, she noted that she had the MDS Coordinator add the orders and update the care plan to include the use of the sling. Interview with the DNS and Administrator on 6/5/2024 at 2:38 PM identified that when a resident utilizes a sling, they would expect the care plan to include the use and the care involved with regards to the use of the sling. They did not identify whether or not there needed to be a physician's order in place when there is a splint in place. Subsequent to surveyor inquiry, Resident #17's care plan was updated to reflect that he/she prefers to wear the left upper arm sling while out of bed with the exclusion of showers, as tolerated for comfort. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #26 was admitted to the facility in March of 2024 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, and dysarthria and anarthria. The physician's orders dated 5/23/2024 directed for a right AFO (ankle foot orthosis) on as tolerated when getting out of bed every day and evening shift. Resident #26's care plan dated 4/4/2024 identified the use of a bed rail to assist with ADLs. The Admission MDS assessment dated [DATE] identified Resident #26 had severe cognitive deficit, required substantial to maximal assistance with lower body dressing and partial to moderate assistance with upper body dressing, chair to bed transfers, and toilet transfers. Observation on 6/3/24 at 4:26 PM identified Resident #26 had an ill-fitting blue and white colored sling on the right upper extremity. The right arm appeared contracted. Observation on 06/04/24 at 1:12 PM identified Resident #26 eating lunch in the dining room with a sling on the right arm. Interview with the Therapy Director on 6/4/24 at 1:35 identified Resident #26 had been using a right leg AFO and a sling to the right arm. The Therapy Director identified that there should be a physician's order for the sling and the use of the sling should be included in the resident's care plan. She further noted she was not sure if the sling was considered a splint and uncertain if the sling should have an order. Interview with the Therapy Director on 6/5/24 at 9:56 AM identified Resident #26 did not have a sling in place when he/she was admitted to the facility. The Therapy Director further identified that she had applied the sling to the right arm during therapy because the arm was in the way and Resident #26 conveyed that the sling felt good, and it had been utilized since that time. Additionally, the Therapy Director identified she had not notified occupational therapy and the use of the sling had not been assessed. She further identified that the use of the sling had not been incorporated into the resident's plan of care. Observation of Resident #17 on 6/5/24 at 1:11 PM identified the resident had a sling to the right arm while feeding himself/herself with the left arm. Interview with the DNS and the Administrator on 6/5/24 at 2:38 PM identified that when a resident utilizes a sling, the expectation would be that the use of the sling be addressed in the plan of care. Subsequent to surveyor inquiry, the use of the sling was added to the care plan with an intervention that it be utilized as tolerated for comfort when out of bed on 6/5/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the MDS Coordinator on 6/5/24 at 11:02 AM identified the Therapy Director gave her a list of residents that needed to have updated orders. The MDS Coordinator identified that usually, for therapy orders, the therapists put them into the paper chart and flags the doctor and then the doctor signs the orders. The MDS Coordinator identified that when the Therapy Director tells her to add the orders, she doesn't contact the doctor. She identified that the residents have been evaluated, she assumed the orders are signed, and she just put the orders in. Interview with APRN #1 on 6/5/ 24 at 11:16 AM identified she considered a sling a splint that the resident should be assessed for and should have a provider order in place if utilized. She further noted that she usually would order the sling per therapy's specifications. Interview with the DNS on 6/5/24 at 1:45 PM regarding splinting and sling placement identified that the expectation for appliance use should be in the care plan in order to direct the plan of care. Additionally, if it is something that the CNA's or nurses should apply, then it should be included in the TAR (treatment administration record) so it can be marked off. Review of the Care Plans, Comprehensive Person-Centered policy identified that a comprehensive, person-centered care plan that included measurable objectives and timetables to meet a resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the facility assessment identified that the facility focuses on person centered care; all needs are met on an individual basis according to their individual preferences. Care plans are developed upon admission and updated as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of the clinical records, review of facility documentation, review of facility policy, and interviews for two of five sampled residents (Resident #2 and Resident #5) reviewed for unnecessary medication, the facility failed to ensure that physician's orders were transcribed and accurately implemented. The findings include: Resident #2's diagnoses included disorder of the immune mechanism, bipolar, type 2 diabetes mellitus, end stage renal disease, depression, and congestive heart failure. The admission MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition, required moderate assistance with personal hygiene and positioning, required maximal assistance with transfers, and utilized antipsychotic (for managing mental health disorders) medication that the assessment noted to be a high-risk medication. The care plan dated 4/1/24 identified Resident #2 used psychoactive medication with interventions that included administer medication as ordered, monitor, record, report to MD side effects and adverse reaction of the psychoactive medications such as unsteady gait, shuffling gait, and ridged muscles shaking (tardive dyskinesia). Review of physician's orders from April/2024 through June 6, 2024, directed to administer Lurasidone/Latuda 60 milligrams (mg) one tablet by mouth once daily for bipolar disorder. According to Latuda.com, the use of the medication may cause serious side effects such as a decrease in blood pressure (orthostatic hypotension). The Psychiatric Nurse Practitioner's (APRN #2) order dated 4/7/24 directed orthostatic blood pressures once weekly times four weeks. Review of Resident #2's clinical record failed to identify that the orthostatic blood pressure was completed as ordered by APRN #2. Interview with the Charge Nurse (LPN #2) on 6/4/24 at 1:00 PM identified that the order for orthostatic blood pressures was entered into the electronic health record directly by APRN #2, but APRN #2 neglected to indicate scheduled times for the blood pressures to be completed. LPN #2 further identified that when a time is not indicated for an action to be done, it does not populate on the Medication Administration Record (MAR) for staff to complete, thus the orthostatic blood pressures were not completed as ordered. Resident #5's diagnoses included disorder of the immune mechanism, schizophrenia, and post-traumatic stress disorder. The admission MDS assessment dated [DATE] identified Resident #5 had moderately impaired cognition, required moderate assistance with personal hygiene, maximal assistance with transfers, and utilized antipsychotic (for managing mental health disorders) medication that the assessment noted to be a high-risk medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 4/15/24 identified Resident #5 used psychoactive medication with interventions that included: administer medication as ordered, monitor, record, report to MD side effects and adverse reaction of the psychoactive medications such as unsteady gait, shuffling gait, ridged muscles shaking (tardive dyskinesia), and frequent falls. The physician's orders dated 4/12/24 directed to administer Zyprexa/Olanzapine 5 milligrams (mg) by mouth two times daily for schizophrenia. According to the Nursing 2023 Drug Handbook the use of Zyprexa (antipsychotic medication) may cause the adverse reaction of orthostatic hypotension (a dropping of the blood pressure when going from a lying or sitting position to standing). The Pharmacy Medication Regimen Review by Consultant Pharmacist dated 4/16/24 recommended was admitted orthostatic blood pressure monitoring once weekly for four weeks due to Resident #5 being on Zyprexa. The Psychiatric Nurse Practitioner (APRN #2) reviewed the Consultant Pharmacist recommendation dated 4/18/24 and agreed with the recommendation and wrote an order directing orthostatic blood pressures once weekly times four weeks. Review of Resident #5's clinical record failed to identify that the orthostatic blood pressure was taken as ordered by APRN #2. Interview with the Staff Development Nurse (LPN #1) on 6/5/24 at 11:05 AM identified that she re-entered the orders written by APRN #2 for Resident #2 and Resident #5 in the electronic health record system on 6/4/24 as APRN #2 had written the orders without a scheduled time for the orthostatic blood pressures to be completed. LPN #2 further noted that APRN #2 was updated on 6/4/24 of the issue. She further identified the facility conducts a 24-hour chart check on the 11:00 PM to 7:00 AM shift of the provider orders in the paper chart but do not check the orders entered into the electronic health record. Interview with APRN #2 on 6/5/24 at 12:30 PM identified that normally inputs her orders into the electronic health record system, and would update the nurse on duty, the DNS, and document in a red binder at the nurse's station of the changes that were made. APRN #2 added that she entered the physicians order for Resident #2 and Resident #5 directing orthostatic blood pressure once weekly times four weeks. APRN #2 identified that she was not formally trained by the facility to input orders into the computerized health record system and was shown briefly by a nurse on the unit. She added that orthostatic blood pressure monitoring would be ordered for residents starting a new psychotropic medication, or with changes made to their current antipsychotic medications. Additionally, APRN #2 identified orthostatic blood pressure monitoring would be required in order to assess side effects and tolerance to the medication. Further, she indicated that there wasn't a need to follow-up whether the orthostatic blood pressure was completed because if there was a concern with the reading the facility would have notified her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 6/5/24 at 1:16 PM identified that she was responsible for reviewing the orders written by the APRN #2 as a result of pharmacy recommendations. The DNS added that she reviewed the orders in the computer but did not check to ensure that it was inputted thoroughly. The DNS identified that the facility's system was to complete a 24-hour chart check of the written orders in the paper chart and not of the electronic health record system. The DNS added that APRN #2 probably had not received formal training on inputting orders in the computer as she was onboarded quickly when the facility lost their previous Psychiatric Nurse Practitioner. The DNS identified that the facility does have an issue with the orthostatic blood pressure orders and was moving forward to address the issue. Review of the Written Orders policy identified that the order entry would include the instructions from the physician or physician representative with date and time. The policy further identified that written orders may only be reviewed by licensed personnel and orders must be written in the electronic health record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, and interviews for one sample resident (Resident #22) who was admitted to the facility within the past six months, the facility failed to ensure physician's orders were signed and dated in a timely manner The findings include: Resident #22's diagnoses included Kaposi's sarcoma, malnutrition, neoplasm related pain, anemia, and depression. The admission MDS assessment dated [DATE] identified Resident #22 was admitted to the facility on [DATE], was without cognitive deficits, required extensive assistance with bed mobility, toileting, hygiene, transfers and was non-ambulatory. Review of the physician's orders from January/2024 through 6/4/24 identified the physician's orders were not signed and/or dated for that period of time. The admission orders should have been signed and then the orders should have been renewed every thirty days for ninety days and then renewed every sixty days thereafter. Interview with the DNS on 6/4/24 at 10:00 AM identified the physician's orders should be signed on admission and renewed every 60 days for resident with Medicaid as the payor source. She identified that she thought the provider was signing the physician's orders after reviewing them. She further identified that all physicians will be educated on signing the physician orders electronically. Interview with APRN #1 on 6/5/24 at 10:00 AM identified that he was reviewing the physician's orders, but he was not signing the physician's orders because he did not have access to the electronic health record system allowing him to sign the physician's orders electronically. Subsequent to surveyor inquiry, he was given access permitting him to be able to sign the physician's orders electronically The Physician Visit policy identified that the attending physician must make the visits in accordance with applicable state and federal regulations. Non-physician practitioners may perform required visits (initial and follow-up), sign orders and sign certification/re-certifications as permitted by state and federal regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47489 Based on review of the facility assessment, review of facility policy and interviews, the facility failed to ensure their licensed staff and CNAs received competency trainings annually. Review of the competency training binder for the facility on 6/6/2024 at 9:30 AM identified that the competency signoffs were blank for the majority of the staff. The staff development provided this binder that was supposed to contain the competency training for the facility staff. Interview and training review with the Staff Development nurse on 06/06/24 at 12:37 PM identified this LPN had been in the staff development position since 4/2023 and is overseen by the DNS. The staff development nurse identified that no training or competency records were turned over to her when she took over the position. Staff Development nurse identified that she is sometimes pulled to do other tasks and is also the MDS coordinator and responsible for the quarterly assessments, annual assessments and admission and discharge assessments and the care plans. I had to put the training on a back burner. There are 11 nurses and 13 CNAs. Of the 24 staff members, 6 (3 nurses/3 CNAs) have competencies for 2023. There were not any records for the 2022 for annual competencies. No competencies have been done in 2024. In-services are done depending on case by case, like if an issue is identified or if we are getting a new patient (i.e. non-binary resident) prior to admission so we are able to provide the care. The Relias trainings are scheduled every month. The employee gets emails reminders that they have trainings to complete. We use the Relias for the annual Abuse and Dementia trainings, and it is a verbal education for anything specific. HR is responsible to keep track of the trainings. Interview with RN #2 on 06/06/24 at 1:16 PM identified he served as the Staff Development person from May 2022 through summer of 2023. He stated he conducted competencies related to hand hygiene and PPE donning and doffing because it was during COVID. He identified that there were not any other competencies addressed at that time. These competencies were identified to be in a manila folder, but the facility is not able to locate this folder. RN #2 identified the facility is implementing a skills fair coming up this year with the hands-on competencies. Interview with the Administrator on 06/06/24 at 1:16 PM identified all of the training and competencies that are done through Relias. This interview also identified the facility underwent a state and federal survey in 2022 and was fined regarding the competencies. The administrator identified there is an upcoming competency fair and was not aware that the competency checks should have been implemented timelier. Interview with the DNS on 06/06/24 at 1:38 PM regarding staff annual competency review and identified that the facility did not have the competencies completed. We were scheduled to do a competency in-service this week but then you guys got here. If you had come next week, then we would have been all set. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Potential for minimal harm Residents Affected - Many	Review of the facility assessment identified that Licensed staff should receive yearly staff competencies in 14 care areas to include personal protective equipment, Wound care, Ostomy care, enteral tube care, enteral tube feeding bolus/pump, indwelling catheter insertion, PICC line dressing, needle safety, glucose testing, hand hygiene, gait belt, Hoyer lift, IV certification, PCA pump. Additionally, the facility assessment identified the CNA staff received yearly competencies to include personal protective equipment, care of a resident with an indwelling catheter, perineal care, hand hygiene, vital signs, gait belt, Hoyer lift, basic IV therapy, CNA documentation review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observations, review of facility policy and interviews, the facility failed to ensure foods were dated and labeled appropriately, discard expired foods, and utilize hygienic practices during the handling of prepared food. The findings include: Observations with the Food Service Manager on [DATE] at 2:45 PM identified the reach-in refrigerator contained the following food items that were covered in plastic wrap but were undated and unlabeled: Two peanut butter and jelly sandwiches A round dough like substance A salami sandwich Three eggs in a bowl A plate containing chicken and roasted potatoes A chicken salad sandwich A pan containing mixed vegetables and ground beef A metal bin containing yellow colored rice in a metal bin Scrambled eggs in a white bowl Shredded cheese in a plastic bin A metal bin containing cooked ziti Thirteen containers of individual servings of sour cream and salsa Interview with the Food Service Manager on [DATE] at 3:00 PM regarding the undated and unlabeled food items identified that the date of preparation or the date of expiration of the identified food items was not identified. He noted that all prepared food should be labeled when it is prepared and kept for no more than three days from the preparation date. Food that is not prepared but removed from another container should be labeled with the original expiration date. The Food Service Manager identified that he did not know why the staff had not labeled or dated any of the food items. Observation on [DATE] at 3:02 PM with the Food Service Supervisor identified the following in the walk-in freezer: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hot Dog/Sausage type meat opened and wrapped in saran wrap with no date label affixed Metal rectangular pan covered with foil labeled with black marker Sheperd's Pie [DATE] Onion rings with no date/label in a plastic bag open to air Noodles frozen in a bag with no date/label 3 bags of alfredo sauce in a box with one pouch opened with a best by date labeled on the box of [DATE] 3 loaves of French bread wrapped in saran wrap with no date/label 2 boxes of veal/beef patties open to air with date of best by [DATE] Pepperoni in a box open to air with a received-on date of [DATE] Mini quiches in a box open to air with a [DATE] received on date on the label A box of French fries containing two bags open to air with no date/label 1 bag of meatballs opened in a plastic bag with a knot tied at the top no date/label A whole cooked turkey wrapped in saran wrap with a cooked date of [DATE] and a use by date of [DATE] Three bags of guacamole with a use by date of [DATE] A box of crab cakes with a received date of [DATE] with an open to air plastic bag inside Sweet potato pie wrapped in saran wrap with no date/label Peach pie wrapped in saran wrap with no date/label Hash browns in a plastic bag open to air with no date/label affixed Gluten free rolls in a plastic bag with no date/label affixed Interview with the Food Service Manager on [DATE] at 3:22 PM identified he would throw away all of the opened to air and undated food items. He also identified that the items in the freezer should be labeled when opened and would be good for 6 months then they should be thrown out and noted it was his responsibility or anyone who sees the items to throw them away if they are past their expiration date or have been in the freezer over 6 months. Observation on [DATE] at 3:25 PM with the Food Service Manager identified the following outdated and/or undated food items in the dry storage area: Ranch dressing mix with no date/label affixed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A box of Rituals Orange pekoe black tea in a box labeled best by [DATE] A box of Rituals Orange pekoe black tea in a box labeled best by [DATE] 2 individual serving boxes of Scooter cereal with a best by date of [DATE] 2 bags of marshmallows without an expiration/use by date and/or a date received 2 large cans of ravioli with a black marker dated ,d+[DATE] (no year identified) and no expiration date noted Interview with the Food Service Manager on [DATE] at 3:38 PM identified the expired items in the dry storage should have been thrown out, which he proceeded to do. He further noted that once items are received, he tries to complete a rotation with the food and believes the expired ravioli cans came from the emergency supply that he was trying to rotate into use. Observation on [DATE] at 3:40 PM with the Food Service Manager of the walk-in refrigerator identified the following undated and/or unlabeled food items: A ham sandwich Seven small bowls of apple crisp covered in plastic wrap Thee muffins wrapped in plastic wrap A lunch bag with the letters R.C. on it with a metal drink bottle next to it Interview with the Food Service Manager on [DATE] at 3:52 PM identified the items in the walk-in refrigerator should have a label identifying the date of preparation, and within three days of the preparation date. He further noted that staff lunch boxes should not be stored in the refrigerator, and indicated there was a refrigerator available for the staff to utilize. Observation of the tray line/food preparation on [DATE] at 12:20 PM identified that during the process of transferring green beans from a cooking tray to a metal bin Dietary Aide #1 without the benefit of gloves, used his hand to guide the green beans into the metal bin. Interview with the Food Service Manager on [DATE] at 12:30 PM identified that Dietary Aide #1 should have not touched the food with his bare hands and should have donned gloves. Review of the Food Receiving and Storage policy directed that refrigerated and frozen foods stored in the refrigerator or freezer should be covered, labeled, and dated (use by date). Dry foods that are stored in bins are removed from original packaging, labeled, and dated (use by date). Review of the Food Preparation and Service Policy directed that during food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and are discarded after each use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for one of five sampled residents (Resident #26), reviewed for immunizations, the facility failed to offer and/or assess for pneumococcal upon admission as required. The findings include: Resident #26 was admitted to the facility in the month of March of 2024 with diagnoses that included disorder of the immune mechanism, schizophrenia, and post-traumatic stress disorder. The Admission MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition. Review of the immunization records for Resident #26 on 6/5/24 at 1:50 PM failed to identify that the pneumococcal vaccine was offered and/or assessed for past immunization. Interview with the Infection Preventionist Nurse (RN #2) on 6/6/24 at 10:42 AM in regards to resident immunizations identified that he asked Resident #26 if he/she wanted to receive the pneumococcal vaccine and he/she refused the vaccine. RN #2 identified that he had failed to document the encounter with the resident in the clinical record. RN #2 further identified that Resident #26 had a conservator and noted that he thought that social services would contact the conservator regarding the resident's vaccination status, but he had failed to follow-up with social services. Additionally, RN #2 noted it was his responsibility to assess, and to offer vaccinations to residents and obtain signed consent from the resident and/or responsible party. Subsequently, RN #2 identified that he approached Resident #26 on 6/6/24 regarding the pneumococcal vaccine and he/she agreed to receive the vaccine. Review of the Pneumococcal Vaccine policy identified that each resident would be assessed for pneumococcal immunization upon admission and would be offered within thirty (30) days of admission to the facility, unless medically contraindicated. The policy further identified that assessment of pneumococcal vaccination status within five working days of the resident's admission or prior. In addition, if refused by the resident/representative appropriate documentation would be documented in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for two of five sampled residents (Resident #2 and Resident #26) reviewed for immunizations, the facility failed to offer and/or assess for COVID-19 immunizations upon admission. The findings include: Resident #2 was admitted to the facility in December of 2023 with diagnoses that included disorder of the immune mechanism, type 2 diabetes mellitus, end stage renal disease, and congestive heart failure. Review of the immunization records for Resident #2 on 6/5/24 at 1:50 PM failed to identify that the COVID-19 vaccine was offered and/or history of past vaccination obtained. Interview with the Infection Preventionist Nurse (RN #2) on 6/6/24 at 10:42 AM identified he was unable to provide any documentation of Resident #2's COVID-19 vaccinations as he did not review their vaccination status upon admission. RN #2 identified that it was his responsibility to assess and to offer vaccine to residents as appropriate, and to ensure that the consent forms were completed prior administration. In addition, RN #2 added it was the practice of the facility for the Infectious Disease physician to review vaccination consent forms and direct the appropriate vaccine for the resident prior to administration. Subsequent to surveyor's inquiry, RN #2 identified that he assessed and offered Resident #2 the COVID-19 vaccination on 6/6/24 and reviewed vaccine consent form with the resident. Resident #26 was admitted to the facility in March of 2024 with diagnoses that included disorder of the immune mechanism, schizophrenia, and post-traumatic stress disorder. The Admission MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition. Review of the immunization records for Resident #26 on 6/5/24 at 1:50 PM failed to identify that the COVID-19 vaccine was offered and/or assessed for past immunization. Interview with the Infection Preventionist Nurse (RN #2) on 6/6/24 at 10:42 AM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075408	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leeway, Inc	40 Albert Street New Haven, CT 06511

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified that he had asked Resident #26 and he/she refused the vaccine but failed to document such encounter with the resident. RN #2 added that Resident #26 had a conservator in which he thought that social services would contact regarding the resident's vaccination status, but he failed to follow-up with social services. He added that it was his responsibility to assess, and to offer vaccination to resident wherein a consent form regarding the vaccination would have been given to the resident/responsible party to review and sign. After which he would give the consent form to the Infectious Disease physician to review for appropriateness prior to administration. RN #2 added that he approached Resident #26 on 6/6/24 regarding the vaccine and he/she agreed to receive the vaccine. RN #2 added vaccination status should be assessed and offered on admission and failed to identify why it was not done and when refused why he had not documented. Subsequent to surveyor's inquiry, Resident #26 was offered COVID-19 vaccination as identified on faxed sent to the Resident #26's conservator on 6/6/24 at 9:20 AM. Review of the COVID-19 Vaccination of Residents policy identified that COVID-19 vaccinations would be offered to each resident unless medically contraindicated or the resident is fully immunized. The policy further identified that residents would be screened for prior vaccination before being offered the vaccine.